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President
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Testimony for the Subcommittee on Indian and Alaska Native Affairs Oversight Hearing on the fiscal year 2013 budget request of the Indian Health Service.
March 6, 2012

Members of the Committee, Thank you for the honor of presenting testimony today.

My name is Jerry Isaac and I am the President of the Tanana Chiefs Conference. TCC is a non-profit intertribal consortium of 39 federally recognized Tribes located in the Interior of Alaska. TCC serves approximately 13,000 Native American people in Fairbanks and our rural villages. Our traditional territory and current services area occupy a mostly roadless area almost the size of Texas, stretching from Fairbanks clear up to the Brooks Range, and over to the Canadian border.

TCC is a Co-Signer of the Alaska Tribal Health Compact under Title V of the Indian Self Determination and Education Assistance Act, Pub. L. 93-638. My testimony will discuss both TCC and another Co-Signer of the Alaska Tribal Health Compact, Southcentral Foundation. SCF serves about 60,000 beneficiaries in Anchorage, the Matanuska-Susitna Valley and 60 rural villages in the Anchorage Service Unit.

I will be testifying on two matters. First, I will provide an overview of the Joint Venture Construction Program and specially address TCC and SCF's Joint Venture staffing needs for two new facilities. Second, I will explain the impact suffered by TCC and others from the contract support cost shortfall, and how that shortfall will have the most impact for those entities starting to operate replacement or joint venture facilities in fiscal year 2013.

1. TCC and SCF require the full staffing package amount in FY 2013, as contractually agreed to in our respective Joint Venture Agreements.

The Joint Venture Construction Program is authorized in Section 818(e) of the Indian Health Care Improvement Act, Public Law 94- 437. The authorization directed the Secretary of HHS to make arrangements with Indian tribes to establish joint venture projects. The program is executed through a JVCP agreement—a contract—in which a tribal entity borrows non-IHS funds for the construction of a tribally owned health care facility, and, in exchange, the IHS promises to lease the facility, to equip the facility and to staff the facility.

In the Conference Report which accompanied the Department of the Interior, Environment, and Related Agencies Appropriation Act, 2010, the conferees explained the importance of the Joint Venture program. That program is a unique way of addressing the persistent backlog in IHS health facilities construction projects serving American Indians and Alaska Natives. The conferees reported, "The conferees believe that the joint venture program provides a cost-effective means to address this backlog and to increase

access to health care services for American Indians and Alaska Natives. The conferees are aware that IHS is currently reviewing competitive applications from Tribes and Tribal organizations to participate in the 2010 joint venture program and encourage the Service to move forward with the process in an expeditious manner."

IHS has followed the direction of Congress and/or the Conference report. In 2010 IHS signed two legally binding separate Joint Venture Construction Agreements with TCC and SCF. In the agreements IHS agreed to "request funding from Congress for Fiscal year on the same basis as IHS requests funding for any other Facilities." Given that IHS has requested funding for the various JV projects across the country at different percentages and not in correlation to clinic opening dates, it appears that IHS has not requested funding on the same basis across all facilities.

TCC and SCF are concerned, to say the least, at the proposed funding for our Joint Venture projects. IHS requested 35% of the staffing package for TCC (or around $8 million) and 50% of the staffing package for SCF (or around $13.5 million) even though each of our facilities will be open twice as long as those percentages reflect. In effect, we are being half funded, even though other facilities are, correctly, being fully funded.

Both TCC and SCF have remained in close contact with IHS throughout the construction of our projects. We are on budget and ahead of schedule. Both Secretary Sebelius and Dr. Roubideaux were able to visit with TCC and SCF last year. Since those visits, both dates of completion for the clinics have moved up. It is possible that the IHS funding requests were based on last year's projected opening dates. Now, TCC's current beneficial occupancy date for our JV clinic is October 15, 2012, and SCF's current beneficial occupancy date for their JV clinic is July 16, 2012. TCC and SCF JV clinics will open much earlier than what is reported in the IHS Budget Justification.

IHS may have requested a smaller percentage of funds for Alaska because the Alaskan projects are larger projects and it may be the trend in the Lower 48 that larger projects are unable to spend the funds appropriated in the first year. But, TCC and SCF need and will spend far more than the IHS requested amounts. Alaska is a unique place in which the additional costs for recruitment, training and program creation are far higher than in the Lower 48.

It is important to note that TCC has never before owned its own primary care medical facility. This is because the majority of our current clinic space is leased from Banner Health at Fairbanks Memorial Hospital (FMH). Additionally, TCC has purchased lab, radiology, housekeeping, laundry, groundskeeping and maintenance services from FMH. These are services that TCC will begin self performing when we move into the new clinic. Already we have started the planning process for the transition and recruitment of the staff we will need later this year.

TCC has involved IHS in all aspects of this project. Staff within IHS have written that our Joint Venture partnership could be characterized as a model for what can be achieved between Tribal Health Organizations and IHS to improve access to health care for

American Indian and Alaska Native people. TCC and SCF are well on our way to upholding our end of the Joint Venture agreements. We need IHS, and Congress, to hold up the government's side of the bargain.

TCC will be fully operational nearly all of FY 2013, and SCF will be fully operational the entire year. Our staffing packages should be provided in the full amounts proportionate to our operations. Any reduction from the full staffing amount will only result in decreasing our ability to provide services to our beneficiaries. It will also be a contract breach of our JV contract with IHS. Worse yet, it could endanger our ability to service the debt we have incurred in constructing the new clinic.

2. The Administration's contract support cost request will worsen the national CSC shortfall and require further program cuts for Self-Determined Tribes; the burden will fall especially hard on Tribes which operating new facilities in FY 2013.

Related to the Joint Venture Construction Program is our concern with IHS's requested funding for contract support costs. These costs are owed to Tribes and tribal organizations like TCC that perform contracts on behalf of the United States pursuant to the Indian Self-Determination Act. "Contract support costs" are the fixed and fully audited costs which we incur and must spend to operate IHS's programs and clinics. The law and our contracts say that these costs must be reimbursed.

The Indian Self Determination Act depends upon a contracting mechanism to carry out its goal of transferring essential governmental functions from federal agency administration to tribal government administration. To carry out that goal and meet contract requirements, the Act requires that IHS fully reimburse every tribal contractor for the "contract support costs" that are necessary to carry out the contracted federal activities. (Cost-reimbursable government contracts similarly require reimbursement of "general and administrative" costs.) Full payment of fixed contract support costs is essential: without it, offsetting program reductions must be made, vacancies cannot be filled, and services are reduced, all to make up for the shortfall. In short, a contract support cost shortfall is equivalent to a program cut.

Funding contract support costs in full permits the restoration of Indian country jobs that are cut when shortfalls occur. The FY 2010 reduction in the contract support cost shortfall produced a stunning increase in Indian country jobs. Third-party revenues generated from these new positions will eventually more than double the number of restored positions, and thereby double the amount of health care tribal organizations like ours will provide in our communities.

The problem is that for 2013, IHS has requested only a $5 million increase. Yet, the current shortfall is already $50 to $60 million, and with several new clinics becoming operational, the FY 2013 shortfall will likely grow to over $90 million. Against that contract requirement, a $5 million increase is obviously inadequate.

When contract support costs are not paid, we have no choice but to take the shortfall in funding out of the programs themselves. Because TCC will be creating and expanding programs to operate the JV Clinic, our reliance on CSC will also expand. This is true for all Tribes initiating new federal facilities, because the initial operation of a new facility is heavily reliant on contract support.

Letting the CSC shortfall increase, on top of underfunding TCC's and SCF's JV staffing requirements, will end up punishing a majority of the Native beneficiaries in Alaska. The government has a legal duty and trust responsibility to provide for the full staffing packages and the full contract support costs which the government, by contract, has committed to pay. We are not expecting a favor; we are only expecting the government to hold up its end of the bargain.

Members of the Committee, Thank you for the honor of presenting testimony today.